The original documents are located in Box 19, folder "Indian Health Care Improvement Act" of the John Marsh Files at the Gerald R. Ford Presidential Library.

JACK MARSH

SEP 27 1976

THE WHITE HOUSE

WASHINGTON

September 27, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: BRADLEY H. PATTERSON, JR.

THROUGH: WILLIAM J. BARODY, JR.

SUBJECT: S. 522 -- The Indian Health Care Improvement Act

I respectfully recommend that you sign S. 522 and issue the attached statement (Tab A).

Most of my reasons for this recommendation are not reflected in the Enrolled Bill Memorandum; they are as follows:

1. For seven years there has been an unbroken series of Presidential actions which have reversed and rectified the past decades of neglect for Native Americans. It has been a brilliant executive/legislative accomplishment in which you and a bipartisan Congress fully share. A veto of this bill would be the first turnaround in that seven-year record and, as such, would have symbolic impact greater than the merits of the bill considered by themselves.

2. This symbolic impact could not come at a more inopportune time.

   (a) Our experience with Indian matters from Alcatraz to Wounded Knee has shown us that while the Indian community itself is small, the latent interest in and sympathy for Indian people in the population generally is widespread, is undiscriminating and is a magnet for media exploitation. The symbolic force of a veto here risks galvanizing that latent sympathy into an attention-getting political backlash among

conservative and independent people, as well as among Democrats.

(b) Carter's staff is keeping close track of Indian matters; (he has sent Messages to all the recent Indian meetings.) A veto of this bill will raise the whole area of Indian affairs up into his target sights.

(c) You have just (properly) vetoed a less important bill on early retirement for non-Indian federal employees. The two vetoes together will have a synergistic effect. Three weeks from today the National Congress of American Indians assembles in Salt Lake City; vetoing the Indian Health bill will convert the Conference into a minor political disaster for us in addition to its longer term negative opinion effect among Indian leaders.

3. The bill is only an authorization measure. While it is true that the Indian community and the Indian Health Service will be encouraged by your signature to recommend appropriations for the full amounts, you and OMB can handle any unjustified requests through the budget machinery, and in that discriminating way -- next December -- rather than thrcugh the sledgehammer of a veto -- in October, protect the budget from excesses. The draft statement (Tab A) makes it clear that your signing the bill does not constitute overpromising or making a commitment to budget the amounts authorized.

4. Contrary to the impression which may be given at the bottom of page 6 of the Enrolled Bill Memorandum, Republican support for this bill is strong; a veto (unless it is of the "pocket" variety) will be overridden.

(a) Joe Skubitz, ranking on the House Interior Committee, joined in the successful effort to have the earlier version of the bill amended, stating:

> If the amendments are adopted, it is a bill which I personally believe the President can sign in good conscience. . .
>
> I can truthfully say that the Interstate

committee has done its best to report a responsible bill, which in our judgment, should be both fiscally and philosophically acceptable to the administration."

(b) On House passage, the following members of the Minority of the House Interior Committee joined Mr. Skubitz in voting for the bill: Messrs. Bauman, Clausen, Johnson, Lagomarsino, Pettis, Smith and Symmes.

(c) Congressman Rhodes is a co-sponsor of the bill and has written you a special letter urging you to sign it.

(d) Senators Dole, Fannin, Goldwater, Bartlett, Domenici, Stevens and Hatfield are supporters of the amended bill.

5. We are on somewhat slippery grounds in opposing the final, amended bill. In unusual steps, both Ranking Member Skubitz and Ranking Member Fannin went out of their way to castigate HEW generally and Secretary Mathews personally for being unwilling earlier on to sit down with the Committees and staffs to work out an acceptable compromise. 53 weeks ago, Senators Fannin and Bartlett had lunch with Secretary Mathews to start this process, but HEW never followed up. The Skubitz and Fannin statements are attached here as Tab B.

6. The Indian Health facilities lack more than "eight-foot-wide halls". When the House and Senate Committee reports pointed out that 25 out of 51 IHS hospitals failed of accreditation by the Joint Commission on Accreditation of Hospitals, they added:

"Many of them are old one-story, wooden frame buildings with inadequate electricity, ventilation, insulation and fire protection systems and of such insufficient size as to seriously jeopardize the health and safety of patients and staff alike."

7. I share Paul O'Neill's concern about special health programs for urban Indians, but the draft signing statement recommended here includes a special instruction to Secretary Mathews to use the bill's authority to avoid duplication.

DRAFT SIGNING STATEMENT FOR S 522

I am today signing S 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have determined that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill itself.

There has never been any question throughout my Administration about the validity of the Congressional Findings in S 522.

There have been differences with the Congress of course about the best methods for meeting the needs identified in those Findings. Earlier versions of this bill contained many undesirable provisions.

But the Congress, after careful and bipartisan review, has modified S 522 and has in my opinion corrected the features which would have been unacceptable.

The proper Committees of the House and Senate have studied the Indian health care delivery system during both the 93rd and 94th Congresses. In spite of the fact that our Executive Branch spending for Indian Health Service activities has grown from $113 million in FY 1969 to $425.6 million in FY 1977, Indian people still lag behind the American people as a whole in having their health needs met. I am persuaded to sign this bill because of the careful documentation that the Committees have made and because of my own personal conviction that our First Americans must no longer be last in opportunity.

The authorizations in this bill may be beyond what future Presidents or future Congresses may be willing or able to approve; there are unneeded authorities given and narrow program categories mandated. But S 522 is a statement of direction of effort toward meeting a clear need, and as such it meets with my personal approval.

Title V of S 522, however, may risk initiating new and unneeded health programs for urban Indians; I am asking the Secretary of Health, Education and Welfare to administer Section 503(a)(9) with great caution, since it is preferable that urban Indian people receive health care from existing local facilities than to start up duplicative programs at unnecessary cost.

Since Title VII of this bill provides for future reports to the Congress from the Secretary, including a review of progress and as assessment of the bill's progress, I believe the Administration can in this way bring to the attention on the Congress any changes then needed to improve the provisions of S 522.

I am proud to point out that this new statute is only the latest in a distinguished series of legislative, executive and judicial actions in the past few years which have totally reversed the shameful policies of the past towards American Indian people. The restorations of Blue Lake, of the Yakima lands, of the Menominees, the Alaska Native Claims Settlement Act, the Indian Financing Act and

the Indian Self-Determination Act, the government's vigorous defense of Indian natural resources and water rights, the resulting milestone Court decisions such as McClanahan, Washington, Mazurie, Stevens and Bryan, the tripling and quadrupling of agency budgets for Indian programs -- are rectifying the sorry past and are enabling our American Government to hold its head high where our American Indian citizens are concerned.

There is much more to do, but this Act and the chain of statutes and policies of which it is a link have set a new direction of which I am proud and which I shall continue.

Gerald R. Ford

SKUBITZ:

death rates, greater disease, and more frequent infant deaths than non-Indians.

It is the Congress which must undertake the necessary initiative here.

It is the Congress which must commit itself to a serious program for Indian health improvement.

But H.R. 2525, unless amended, is not the answer.

The legislation is irresponsible, for it makes firm commitments of staggering amounts of taxpayers' money for up to 7 years, when not even the best of experts is able to estimate with accuracy Indian health needs or medical costs that far in the future.

The legislation is pure puffery, for the committee makes bold promises which it knows no Appropriations Committee could fully endorse and which no administration in its right fiscal mind could tolerate.

For many years the Interior Committee has had nearly exclusive jurisdiction over Indian matters.

Thus, the committee has responsibility to the Indian people to present their case in a wise and defensible manner.

To be taken seriously, the committee should recommend seriously.

Even given the state of Indian health, I still cannot defend a 434-percent increase over the President's budget request for first year funds for construction of Indian health facilities.

I cannot defend $16.8 million for an Indian school of medicine that is not even endorsed by the Indians.

I cannot defend a 7-year package which totals $1.2 billion when this committee has no idea what Indian health needs will be in 1983, when this committee has no idea what medical costs or technology will be in 1983, when this committee has not the slightest notion as to whether this program will solve Indian health problems—in 7 years—or "70 times 7" years.

I cannot defend this committee "washing its hands" of the bill and putting all the heat on the President.

If he vetoes this irresponsible bill he gets the criticism when, in reality, this committee deserves it.

You may call this bill a "commitment to Indian health."

I call it an evasion of legislative responsibility.

Mr. Chairman, I followed this bill through both the Interior and Interstate Committees.

Needless to say, I was very disappointed with the bill as reported by the Interior Committee.

However, the amendments to H.R. 2525 to be presented by the Interstate Committe go a long way toward correcting many of the bill's inadequacies.

Most importantly, the authorization has been reduced from 7 years to 3.

May I emphasize to my colleagues that such a 3-year authorization does not mean that the Indian health program will be abruptly terminated after only 3 years.

Instead, the Congress commits itself to a realistic and rational 3-year program, and then promises to reevaluate the Indian health situation in the light of the program's successes and failures.

The Interstate amendments will reduce the first year construction allocations for medical facilities.

Although I believe that the $67 million provided is still far too much, it is a significant improvement over the Interior Committee's recommendation of $124 million.

Finally, the amendments to be offered will strike the provision which creates an American Indian medical school.

With the adoption of these amendments I feel that H.R. 2525, although not perfect, nevertheless is an acceptable bill and provides a program which will take giant strides toward improving the Indian health situation.

If the amendments are adopted, it is a bill which I personally believe the President can sign in good conscience.

If the amendments are not adopted, Congress will send to the President an irresponsible bill bloated with inefficiency, waste, and duplication.

Approving H.R. 2525 without amending it plays "chicken" with the White House and invites a veto.

We gain nothing by losing an Indian health program to a successful veto.

Even more importantly, the Indian population gains nothing, despite our rhetoric, promises, and intentions.

Let us be realistic, let us agree to commit ourselves to a comprehensive program which will bring the level of Indian health up to the standards of the non-Indian population.

Let us agree on a proposal which both the administration, the Congress, and the American people—Indian or otherwise—will recognize as serious and reasoned legislation.

Mr. Chairman, I will support H.R. 2525 if the House accepts the Interstate amendments.

I hope the administration has adopted a similar position.

I just want to say a few more words on this matter.

It is almost an understatement to say I have been distressed and frustrated in working with the administration on this legislation.

I can accept the fact that often the position adopted by the administration is different from my own.

I recognize that as inevitable, for in the final analysis, we are accountable to two different constitutencies.

But I cannot accept the uncooperative spirit I have encountered in dealing with the Department of Health, Education, and Welfare about this bill.

I would like to state, for the record, the Department's position on this bill, but I honestly do not know what it is.

A number of times I called the Secretary's office to ascertain the administration's opinion but, unfortunately, Mr. Mathews has been either "too busy" or "out of the office" so much that, at present, I have no idea what HEW wants.

Perhaps Mr. Mathews has seen fit to communicate to other Members of this House the administration's position, but he has ignored completely the ranking Republican on the committee with primary jurisdiction over the bill and who also serves on the committee which handles health matters.

I can truthfully state that the Interstate committee has done its best to report a responsible bill, which, in our judgment, should be both fiscally and philosophically acceptable to the administration.

If the President later concludes that this Indian health package is unacceptable or too costly, I respectfully suggest that such a position should have been expressed weeks ago by the Office of the Secretary of Health, Education, and Welfare.

Mr. YOUNG of Alaska. Mr. Chairman, I yield such time as he may consume to the distinguished minority leader, the gentleman from Arizona (Mr. RHODES).

(Mr. RHODES asked and was given permission to revise and extend his remarks.)

Mr. RHODES. Mr. Chairman, the bill we are considering today, H.R. 2525, deserves the support of this Congress. It provides for long unmet health care needs of our American Indian population.

Since the mid-1800's, Indian health care has lagged behind that available to our general population and serious disease has afflicted our Indian people and shortened their lifespan. This bill is similar to H.R. 7852 which I introduced. It simply is an effort to remedy the inadequacies of Indian health care.

Basically the bill outlines a 7-year program to upgrade Indian health care delivery. It provides for new hospitals where none exist, and modernization of obsolete facilities. It would provide safe water supplies and adequate sanitary waste disposal systems.

The bill would encourage Indians to participate more actively in management of health care programs, and to seek help from community health assistance facilities.

It provides for participation in medicare ad medicaid programs through the Indian Health Service. In addition, it would establish an Indian School of Medicine to insure that properly trained Indian physicians and other health personnel will be available in the future.

Mr. Chairman, this is a sound approach to the unmet health care needs of our Indian people. It encourages them to be part of the system; to participate in cooperative Federal and local programs, and to provide health care manpower, now in seriously short supply.

The Indian Health Care Improvement Act has attracted strong bipartisan support in both houses of the Congress. I believe this is a good bill, a practical and constructive move to help deserving people meet a major challenge. I urge that my colleagues support H.R. 2525 so this worthwhile program may begin.

The CHAIRMAN. Does the gentleman from Alaska (Mr. YOUNG) desire to yield further time?

Mr. YOUNG of Alaska. Not at this time, Mr. Chairman.

The CHAIRMAN. Does the gentleman from Florida (Mr. ROGERS) desire to yield time?

INDIAN HEALTH CARE IMPROVEMENT ACT

Mr. FANNIN. Mr. President, I concur with the distinguished chairman of the committee.

For nearly 2½ years, the Congress has been considering legislation to strengthen the quality of Indian health care services. Beginning with hearings in 1973 on the shortages in Indian health manpower, the Congress has, through hearings, investigations, and GAO studies, confronted Indian health care deficiencies and needs. It would serve no useful purpose to remind the Senate once again of these problems, except to say that these problems remain unresolved, awaiting resolution.

In response, the Senate Interior Committee developed the Indian Health Care Improvement Act which the Senate on two occasions approved unanimously. This legislation was designed to expand, under a carefully developed plan, the level of health care services provided to Indian people. In addition, the bill addressed the crisis in manpower facing the IHS and the inadequate and unsafe facilities which the IHS must utilize in treating Indian citizens. The Senate in approving this legislation was confident that its approach, which was comprehensive in scope, addressed in a reasonable way the neglect which limited resources had fostered within the Indian Health Service. In doing so, the Senate committed itself to establishing better health care for Indian citizens as a priority concern of the Federal Government.

In the House, three major authorizing Committees, Interior and Insular Affairs, Interstate and Foreign Commerce and Ways and Means examined this issue in depth and recommended approval of the Senate-passed bill, S. 522, as amended. The House concurred by a vote of 310 to 9. By this vote, the House committed itself to strengthening our Indian health care program and joined with the Senate in making Indian health care a matter of highest importance.

As amended by the House, S. 522 was modified only to the extent of its commitment. As passed by the Senate, S. 522 had authorized the expenditure of $1.6 billion over 7 years. This approach was neither arbitrary, unreasonable or excessive as it had been our policy to limit the impact of these much needed expenditures while assuring a strong commitment to eliminating the deficiencies in manpower, patient care services and facilities. In approving this 7-year program, the Senate had sought to avoid those problems that might occur with a short-term crisis program.

The House, after careful deliberation, determined that it would be unwise to make such a long-term commitment. It amended S. 522 by authorizing the expenditure of approximately $500 million over a 3-year period. It did, however, commit itself to reviewing the balance of the 7-year plan following the initial 3-year authorization period. Nevertheless, the bill, as amended, remains virtually intact in terms of its basic structure. The Senate had designed a bill which contained a series of programs which were interrelated and complementary. This approach, to which the House agreed, is fundamental to successfully overcoming the overall problems in the Indian health care delivery system. Therefore, because the House retained the basic structure developed by the Senate and is committed to reviewing the balance of the 7-year plan following the 3-year authorization period, I can accept S. 522 as amended and urge my Senate colleagues, without reservation, to approve this much needed legislation.

There is one issue, however, in the bill which needs to be discussed so that the record is quite clear as to congressional intent. During its consideration of title I, dealing with manpower, the House Interstate and Foreign Commerce Committee approved an amendment to establish the section 104, health scholarship program within the National Health Service Corps program. This amendment was unacceptable initially to the Senate because it created a situation in which the Indian Health Service would be unable to control the program. It was definitely the intent of the Senate to provide the Indian Health Service with sufficient authority to manage its own manpower programs as developed within title I, so that it would not have to rely on other existing programs which have proven unable to meet IHS needs. The amendment by the House appeared to have weakened that approach causing us great concern. In response, the House agreed to a further amendment which would insure that the Indian Health Service could write the prescription for its manpower needs while allowing the National Health Service Corps to administer the details of the scholarship application and funding process. In view of this clarification, I have no further objection to the House amendment with the understanding that the Indian Health Service will have the authority to determine scholarship recipients and the distribution of scholarships among those health care professions that are either in demand or expected to be in demand within the Indian Health Service.

Mr. President, as we move to conclude the final action on the Indian Health Care Improvement Act, there hangs over this much needed legislation the threat of a veto. This threat deeply concerns me; but let me be very clear that I do not intend to stand idly by in the event of a veto.

This threat has existed since Congress began its consideration of the Indian Health Care Improvement Act. The position of the Department of Health, Education, and Welfare has always been negative. In letter after letter, in statement after statement, the Department has never changed its mind that this legislation was unnecessary, too expensive, excessive in scope, and inconsistent with the objectives of the administration.

The Department has failed to even practice the art of compromise, conciliation, and cooperation in the development of this bill. On two occasions in this and the last Congress, my staff met with departmental officials to discuss agreement on this bill. Their attitude was clearly negative and exhibited an unwillingness to work out an acceptable compromise. Senator BARTLETT and I even met with Secretary Mathews to encourage support and to possibly open communications on resolving the Department's posture of opposition. It was my impression following this meeting that the Department was interested in the problems of the Indian Health Service and in discussing possible approaches to their solution both within nad without the context of the Indian Health Care Improvement Act. Yet, progress toward agreement was conspicuous by its absence. The Department made no effort whatsoever to produce any alternatives and, in fact, I never heard from Secretary Mathews on the subject again. In view of the unbending opposition by the Department, the Congress had no choice but to proceed as best it could in developing legislation that would address the very critical health care problems faced by Indian citizens.

Time and again the Department indicated that this legislation would create undue expectations among the Indian people. Yet, what expectations does the Department provide to Indian people themselves when their own budget requests for IHS contains funds which are inadequate to effectively address patient care needs and the obvious need for better facilities. For example, since fiscal year 1969, through fiscal year 1977, the Department has on its own requested only enough funds to construct two replacement hospitals. Yet, as the Congress knows, the needs of the IHS facilities far exceed the level of that support.

In summary, the Department's position on this legislation is without merit and this troubles me. Despite the Department's opposition to S. 522, its own

statements reflect the concern that the quality of care that IHS is able to provide is inadequate. In a recent letter, for example, to Congressman RHODES, the House minority leader, the Undersecretary of HEW, Marjorie Lynch, acknowledges that fact by stating that the Department, and I quote, "is working toward raising the health status of Indians to at least a level equal to that of the non-Indian population." This admission by the Department itself that Indian health care is inadequate makes their opposition to this legislation somewhat mystifying.

In my opinion, the Department and Congress agree that Indian health care services are inadequate. Where we disagree is the speed with which we should address the problem. Congress is in a mood, however, to move ahead more rapidly than the Department. In view of the needs which have been so completely documented both within Congress and in the Department itself, we are at a loss to understand why the Department feels so compelled to drag its feet in addressing this problem.

Mr. President, this legislation has enjoyed broad bipartisan support within the Congress as well as among virtually every important national health organization. But more importantly, it is supported wholeheartedly by the Indian people themselves as better health is their number one priority. Only the Department stands in lone opposition to this much needed legislation.

Mr. President, it is my hope that President Ford will recognize the importance of this legislation. The Congress has produced a reasonable piece of legislation which will assure a better health care delivery system for our Indian people. In that spirit, I hope the Persident will approve the Indian Health Care Improvement Act as a positive commitment toward securing a better life for our Indian citizens.

Mr. President, I feel very keenly about this legislation. It is legislation that will be of great value to our Indian people. I do not consider there is anything more important to our Indian people than their health care.

Mr. President, I want to commend the outstanding leadership of my chairman, Senator JACKSON, in assisting in the development of this legislation. His leadership and concern for resolving the problems of Indian health care programs will long be remembered.

Mr. President, I urge adoption of the Senate amendment and approval of S. 522 as amended.

I yield to the Senator from Oklahoma.

Mr. BARTLETT. Mr. President, it is with great pleasure that I rise today in support of S. 522, the Indian Health Care Improvement Act, as passed by the House with the clarifying and substantive changes offered in the Fannin/Jackson amendment. I sincerely hope the Senate will, as it has done twice before, act favorably and expeditiously on this measure. I can see no need to debate the issues involved in this bill to any degree here today because they have been thoroughly discussed by the Senate twice before in the Interior Committee, and the same conclusion was reached in both instances—that there clearly exists a very great need for a comprehensive health care plan to meet the unmet health care needs of the Indian people of this country.

The staffs of both Houses of this Congress have worked long and diligently to devise such a plan, and in my opinion have come up with an excellent one. This plan, S. 522, addresses the long-standing and often neglected responsibility of the Federal Government, that is, the responsibility to provide health care services to native Americans in this country. The health care needs of this segment of the population have heretofore been given piecemeal attention, an approach which I feel has contributed considerably to their present day health status. Although the Indian Health Service has in recent years made significant advances in its efforts to provide quality health care to the Indian people, the unmet health needs are still alarmingly high. Their health needs far exceed that of the general population.

Even though the Department of Health, Education, and Welfare is just as much aware of this fact as I, it opposes enactment of this much needed legislation. It would not be difficult for me to understand HEW's position on this bill if the health care status of Indian people were on a par with that of the general population, but recognizing the great unmet need that clearly exists in the quality of health care services delivered to Indian people and recognizing that the responsibility for correcting this grave situation is clearly that of the Federal Government, I find the position of HEW on this bill to be unconscionable.

Both Senator FANNIN and I have met with Secretary Matthews and others in the Department of HEW to point out to them the merits of this bill, but our efforts were to no avail. HEW has still not seen the need to support this legislation and, in fact, has indicated that it will recommend a veto if the bill is presented to the President for approval.

Mr. President, I have been a strong supporter of this bill from its inception, and I will continue to lend my support to it until it is signed into law by the President of the United States. I feel strongly that the Federal Government has failed to provide an adequate Indian health bill. Enactment of S. 522 eliminates many of the existing deficiencies in Indian health care services.

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: September 30 Time: 315pm

FOR ACTION: Sarah Massengale
Bobbie Kilberg
Max Friedersdorf
Robert Hartmann
Brad Patterson
Paul O'Neill
Bill Seidman

cc (for information): Jack Marsh
Jim Connor
Ed Schmults

FROM THE STAFF SECRETARY

DUE: Date: September 30 Time: asap

SUBJECT:

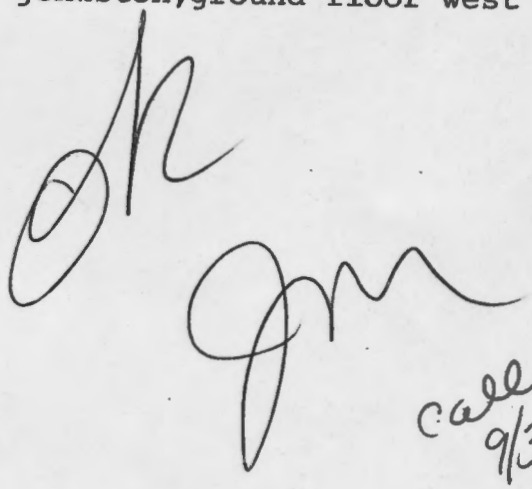
Signing Statement - S.522 Indian Health Care

ACTION REQUESTED:

____ For Necessary Action
____ For Your Recommendations
____ Prepare Agenda and Brief
____ Draft Reply
x For Your Comments
____ Draft Remarks

REMARKS:

please return to judy johnston, ground floor west wing



called 9/30 dl

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

S. 522 - Indian Health Care Improvement Act Signing Statement

I am today signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have determined that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from $107 million in FY 1969 to an estimated $417 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our First Americans must not be last in opportunity.

Some of the authorizations in this bill are duplicative of existing authorities and there is an unfortunate proliferation of narrow categorical programs. But still, S. 522 is a statement of direction of effort and, as such, it meets with my personal approval.

Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education and Welfare, including a review of progress under the terms of the new Act. I believe the Administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

On balance, this bill is a positive step and I am pleased to sign it.

THE WHITE HOUSE
WASHINGTON

Jack -

I spoke w/ Sen. Fannin re attached.

FYI, no decision has as yet been made (as advises OMB). It has until Friday, Oct. 1 to act.

Fannin appreciated the follow-up. We had pleasant chat about the bill, Ted Marrs, etc.

Russ

Famin /

Indian

Health Bill

Status (On floor)

oct. 1st +

THE WHITE HOUSE
WASHINGTON

Recommend approval with signing ceremony, as we discussed —

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.: SEP 27 1976

Date: September 25 Time: 1000am

FOR ~~ACTION~~: Brad Patterson
Max Friedersdorf
Bobbie Kilberg
Robert Hartmann (veto message attached)
Spencer Johnson
Bill Seidman

cc (for information): Jack Marsh
Jim Connor
Ed Schmults
Dick Parsons
George Humphreys

FROM THE STAFF SECRETARY

DUE: Date: September 27 Time: 500pm

SUBJECT:

S. 522-Indian Health Care Improvement Act,

ACTION REQUESTED:

____ For Necessary Action
____ Prepare Agenda and Brief
x ____ For Your Comments
____ For Your Recommendations
____ Draft Reply
____ Draft Remarks

REMARKS:

please return to judy johnston, ground floor west wing

approved

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

James M. Cannon
For the President

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

SEP 23 1976

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 522 - Indian Health Care Improvement Act
Sponsor - Sen. Jackson (D) Washington and 24 others

Last Day for Action

October 1, 1976 - Friday

Purpose

Authorizes new categorical programs and substantially increases appropriation authorization levels for Indian Health Service programs of the Department of Health, Education, and Welfare (HEW).

Agency Recommendations

Office of Management and Budget	Disapproval (Veto message attached)
Department of Health, Education, and Welfare	Approval
Department of the Interior	Approval

Discussion

S. 522 would authorize approximately 20 new categorical programs at substantial funding levels, with the stated objective of improving the health status of Indians and Alaskan natives. The bill was considered by four different Congressional committees during this Congress. The Committees' clear intent is that the appropriation authorizations be in addition to current funding levels.

This legislation was approved in the Senate by unanimous consent and in the House by a 310-9 vote. The Senate concurred in the House-passed bill by a 78-0 vote on September 9, 1976.

The major provisions of S. 522 would:

-- establish a new program of scholarships for Indians desiring to pursue health training, as well as assistance to those serving Indians,

-- authorize numerous new narrow categorical programs for the delivery of health services,

-- authorize a specific program for the construction and modernization of health facilities, including water supply and waste disposal facilities,

-- remove the existing prohibition against Medicare and Medicaid reimbursements to Federal Indian Health Service facilities, and

-- establish a new program of services for non-federally-recognized Indians living in urban areas.

The Senate and House Interior and Insular Affairs Committees both expressed the view that S. 522 is needed because Indian and Alaska natives suffer a health status considerably below that of the general population. The Committees attribute the lower health status to inadequate and understaffed health facilities, lack of access to health services, and lack of safe water and sanitary waste disposal services. HEW, in testimony and reports to the Congress, strongly opposed enactment of the legislation, except for the extension of Medicare and Medicaid reimbursements to eligible beneficiaries in Indian Health Service facilities. HEW's position was based on marked improvement in the health status of Indians over the past decade, generally liberal funding levels for Indian health activities, and the fact that all of the proposed activities can be conducted under existing legislation. Moreover, HEW stated that the authorization levels would raise unrealistic expectations of the resources the Federal Government could afford to devote to this purpose.

Major provisions

Student assistance. S. 522 would authorize 5 new programs designed to increase generally the number of health professionals serving Indians and to increase specifically the number of Indians receiving health training. The programs would:

-- provide grants and scholarships to recruit, prepare, and enroll Indians in health professions schools,

-- authorize scholarship grant recipients to be employed in the Indian Health Service (IHS) during nonacademic periods, and

-- authorize continuing education allowances to all IHS health professionals for professional consultation and refresher training courses.

These programs would be in addition to HEW's broad programs of assistance to medical students and schools under which HEW can already give priority to disadvantaged students, including Indians.

Health services and facilities. S. 522 would authorize a broad range of new programs and substantially increase the numbers of health service personnel over current levels; e.g., it would authorize an increase of 425 new personnel in 1978, 515 in 1979 and 593 in 1980--a total of 1,533. This would be in addition to the current IHS staffing level of 8,800. Programs specified in S. 522 would include patient care, field health, dental care, mental health (including community and inpatient mental health services, model dormitory mental health services, therapeutic and residential treatment centers, and the training of traditional Indian practitioners in mental health) and alcoholism treatment and control. The bill would also direct HEW to apportion at least 1% of all funds authorized for Indian health services for research in each health service area.

In addition, S. 522 would specifically authorize the construction and renovation of Indian hospitals, health centers, health stations and staff housing as well as safe water and sanitary waste disposal facilities in Indian homes and communities. The enrolled bill would make eligible for federally provided sanitation facilities certain Indian tribes currently not eligible for such assistance, e.g., the Senecas and Mohawks of New York. This provision would have the effect of expanding the eligible Indian population by approximately 7,000. Preference to Indian firms would be authorized in awarding construction and renovation contracts for IHS facilities and for the construction of clean water and sanitation facilities for Indians.

Medicare and Medicaid reimbursements. Under current law, IHS hospitals, as Federal facilities, cannot receive reimbursement from Medicare or Medicaid for either Indians or non-Indians. These facilities, however, serve as the principal health delivery system for reservation Indians. S. 522 would make them eligible for Medicare and Medicaid reimbursement as long as they meet required standards or have an acceptable plan to bring a facility into compliance within 2 years. HEW favored this provision, but opposed related provisions in S. 522 that would:

-- prohibit consideration of third-party reimbursements received by IHS in determining appropriation levels for IHS facilities, and

-- require the Federal Government to reimburse 100%--rather than 50% to 80% under current law--State Medicaid agencies which in turn reimburse IHS facilities.

The Secretary would be required to maintain a special revolving fund into which these reimbursements would be paid to be used solely for facilities improvement.

Urban Indian programs. S. 522 would authorize HEW to enter into contracts with organizations of Indians living in urban areas for the purpose of enabling the organizations to identify and assist in providing needed health services. The bill also specifies criteria HEW must consider in selecting the urban Indian organizations, contract conditions, and reporting requirements.

Other provisions. In addition, S. 522 would:

-- authorize HEW to conduct a study to determine the need for and feasibility of establishing a school of medicine to train Indian health professionals;

-- require HEW to promulgate regulations to implement the Act, to develop and submit to Congress--within eight months--a plan for implementation of the specific authorities in S. 522, and to submit annual reports to the Congress and additional reports on expenditures and recommendations for additional appropriation authorizations,

-- authorize HEW to enter into leases of up to 20 years with Indian tribes to construct health facilities. The purpose of this provision is to allow Indians to construct, staff, equip and maintain health facilities and lease them at full cost--including salaries, drugs and equipment--to the IHS. Cost for this would be in addition to the specific amounts authorized and would involve long term commitments for Federal funds.

Cost and budget impact. S. 522 would authorize a total of $480 million for the first three years of the bill, fiscal years 1978-1980, including $145 million for fiscal year 1978. The clear legislative intent is that the amounts authorized to be appropriated be in addition to current appropriation levels. The 1977 budget proposed $395 million for Indian health programs, but the Interior appropriation bill for fiscal year 1977, which you approved, contains $425 million for the IHS--a 230% increase over the 1970 appropriation of $128 million. Even if adjusted at a liberal inflation rate of 10% per year, the increase in funding since 1970 amounts to more than 100%.

A detailed summary of the amounts authorized by S. 522 for Indian health programs is attached to this memorandum.

Arguments in favor of approval

1. The Congressional committees believe that S. 522 would concentrate Federal resources on meeting deficiencies in Indian health services and facilities through a sustained and coordinated effort. The Committees state that health statistics and other indicators of health status--e.g., incidence of tuberculosis, infant mortality, ratio of physicians--demonstrate the need for targeting special Federal resources on Indian health problems.

2. There are indications that the Congress believes it has met important Administration objections, e.g., the potential cost of S. 522 has been reduced from $1.6 billion to $481 million in response to HEW opposition (this was accomplished by reducing the number of years with specific authorization amounts from seven to three and authorizing the outyears at "such sums"). Despite the high authorizations, more realistic appropriations levels can probably be achieved through the budget process.

3. S. 522 has broad congressional and interest group support. It was approved by both Houses by nearly

unanimous votes and has been endorsed by several national health organizations, including the American Dental Association, the American Academy of Pediatrics and the American Medical Association.

4. Congressional proponents, Interior and HEW suggest that your approval of S. 522 would demonstrate a positive commitment to solving Indian health care problems and would signify to Indian people a recognition of one of their priority problems and a real concern for and interest in them.

5. Although S. 522 duplicates many existing HEW programs, it could be viewed as a follow-on step to other laws enacted in recent years--e.g., the Indian Financing Act, the Indian Self-Determination and Education Assistance Act, the Indian manpower component of the Comprehensive Employment and Training Act of 1973--which have been directed toward improving the economic, educational and social status of Indians.

Arguments against approval

1. S. 522 is a prime example of unnecessary and inappropriate Congressional enactments. The bill would add some 20 new narrow categorical programs and appropriation authorizations to an already large array of existing Federal activities aimed at improving the health of Indians. All of the proposed program activities can be conducted under the broad flexible legislative authorities of the Snyder Act and other laws. For example, Indians and non-Indians desiring to serve in reservation areas are already given special consideration under HEW's health professions and National Health Service Scholarship programs.

2. The authorization levels in S. 522 are significantly higher than warranted and raise highly unrealistic expectations of what the Federal Government can or will provide. Moreover, the cost reduction claimed by Congressional proponents of S. 522 is spurious at best, since it was achieved by substituting "such sums" language for specific authorization amounts for the last 4 years of the 7-year authorization period. Other hidden additional costs would arise from contractual arrangements and lease agreements with Indian tribes and Indian organizations. As the minority members of the House Interstate and Foreign Commerce Committee stated, "These levels are grotesque when viewed in the light of budgetary increases totaling over 200% in

the past eight years, and the definite progress in improving Indian health through priorities given to these programs over many competing demands."

3. Substantial Federal funds are already being spent on Indian health. The Administration has indicated its strong commitment to improving the health status of Indians and Alaska natives. As noted above, you have approved a 1977 level of $425 million for the Indian Health Service, a 230% increase since 1970 which amounts to $771 for each Indian or $3,084 for an Indian family of four. These amounts do not include services provided to the eligible Indian population from other Federal health programs.

4. Contrary to the negative emphasis in Congressional committee reports, very substantial improvements have been made over the past several years in the health status of Indians. Dramatic reductions are apparent in such areas as Indian and infant death rates and the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases. No evidence has been developed to warrant the conclusion that a vast infusion of funds for additional and traditional health services such as proposed in S. 522 will significantly improve the health status of Indians.

To a large extent, alcoholism, suicide and accidents are a part of cultural and reservation conditions not readily amenable to traditional health and mental health services. Moreover, it is not clear that forcing IHS hospitals to comply to Joint Commission on Accreditation of Hospitals (JCAH) standards at high cost will result in improved quality of care since many of the standards JCAH applies, e.g., requiring halls to be 8 feet in width cannot be directly related to quality, particularly when the small size of IHS facilities is considered.

5. The provisions singling out non-reservation Indians living in urban areas for special health programs not only duplicate existing narrow categorical programs, e.g., community mental health centers, which provide services to all members of the community including Indians and other disadvantaged groups, but are conceptually at odds with your health block grant proposal that would give the States Federal funds and clear authority and responsibility in this area.

Recommendations

HEW, in its attached views letter on S. 522, recommends approval, stating: "At this stage ...the Administration can only approve or disapprove the bill as a whole." Noting that S. 522 would for the first time permit Indians to effectively use Medicare and Medicaid benefits, HEW states "If Native Americans are to be fully integrated into the mainstream of the American health care system, and in particular in terms of a future national health insurance program, they must be given meaningful participation in, and develop familiarity with, the most extensive programs we have in this area to date." HEW concludes that "approval of this bill would reaffirm the Administration's real concern for and interest in Native Americans; disapproval would adversely affect the view Native Americans and others have as to the Administration's commitment to Native Americans."

Interior also recommends approval of S. 522. Interior states "...we believe it is essential that the President affirm the commitment to improved Indian health as embodied in S. 522, and which has received the overwhelming endorsement of the Indian people."

* * * * * * * *

We believe S. 522 is a particularly egregious example of unnecessary legislation that will result in highly unrealistic expectations among the very group it is intended to help. As pointed out previously, all of the program activities authorized by S. 522 can be accomplished under existing legislative authority.

Moreover, funding of Indian health activities has been increased substantially during the past few years and has resulted in dramatic improvements in the status of Indian health. In 1977, $425 million will be spent by a force of over 8,800 Federal employees. No other segment of American society receives comparable Federal resources for health.

We do not find any of the arguments offered by the Congress or by the Departments of HEW or Interior sufficiently compelling to recommend approval of S. 522, particularly

in light of the special priority already given to Indian health programs. Accordingly, on the merits, we recommend that you veto S. 522 and have attached a draft veto message for your consideration.

Paul H. O'Neill
Acting Director

Enclosures

Attachment

S. 522--Indian Health Care Improvement Act
(Budget Authority in $ millions)

	Fiscal Years 2/		
	1978	1979	1980
Student assistance			
Recruitment and post-secondary assistance	.9	1.5	1.8
Scholarships:			
Preparatory	.8	1.0	1.3
Health professions	5.5	6.3	7.2
Indian Health Service extern program	.6	.8	1.0
Subtotal	7.8	9.6	11.3
Continuing professions education	.1	.2	.3
Health services			
Patient care	-	8.5	16.2
Field health	-	3.3	5.5
Dental care	-	1.5	1.5
Mental health	-	3.4	5.1
Alcoholism	4.0	9.0	9.2
Maintenance	-	3.0	4.0
Subtotal	14.0 1/	28.7	41.5
Health facilities			
Hospitals	67.2	73.3	49.7
Health centers	7.0	6.2	3.7
Staff housing	1.2	21.7	4.1
Subtotal	75.4	101.2	57.5
Sanitation and safe water construction			
Existing homes	43.0	30.0	30.0
New homes	"such sums"	"such sums"	"such sums"
Health services for urban (non-reservation) Indians	5.0	10.0	15.0
Total, specific authorizations	145.3	179.7	155.6

1/ Includes $10 million for all of the health services programs other than alcoholism.

2/ The bill authorizes "such sums" for fiscal years 1981-1984.

TO THE SENATE

I return without my approval, S. 522, the "Indian Health Care Improvement Act."

I return this bill to Congress reluctantly because I strongly support any responsible efforts that will result in improving the health of our first Americans. The "Interior and Related Agencies Appropriations Act, 1977," which I approved just last July, included $425 million for Indian health programs. This amounts to spending by the Indian Health Service alone of $771 for every Indian and Alaskan Native, or $3,084 for a family of four, and an increase in funding levels of 230% just since 1970. I believe this growth reflects a strong commitment to the health needs of Indians and Alaskan Natives. No other segment of American society receives comparable Federal resources for health.

At the same time, I must oppose unnecessary and undesirable legislation. S. 522 is objectionable because it would unnecessarily authorize 20 new categorical health programs at funding levels which can only raise unrealistic expectations. The administration of Indian health programs--which currently benefit from flexible and discretionary authorities--would be made considerably more complicated by S. 522.

Substantial improvements have been made over the past few years in the status of Indian health. Dramatic reductions have been made under current authorities in such areas as Indian adult and infant mortality rates, as well as in the incidence of tuberculosis, influenza and pneumonia, gastritis and related diseases. There is no demonstrable evidence that a vast infusion of funds, such as proposed by S. 522, would achieve better or faster

results than are being achieved under orderly program growth.

Indian health programs have received, and will continue to receive, ample funding under existing program authorizations. I am confident that the priority given to this area in the past will continue without S. 522.

THE WHITE HOUSE

September , 1976

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Honorable James T. Lynn
Director, Office of Management
and Budget
Washington, D. C. 20503

SEP 23 1976

Dear Mr. Lynn:

This is in response to your request for a report on S. 522, an enrolled bill "To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes."

In summary, we recommend that the President sign the enrolled bill because he will thereby affirm in the eyes of Indians and others this Administration's strong commitment to advancing the welfare of our Native Americans; the bill's provisions largely overlap existing legal authority but represent a congressional statement of support for Indian health activities.

The enrolled bill would provide additional appropriation authorizations of approximately $480 million for the fiscal years 1978 through 1980 for specific Indian health programs in the areas of manpower training, services, and facilities; under present law, funds may be appropriated for Indian health activities up to any amount. The Administration recommended $395 million in appropriations for Indian health services and facilities for fiscal year 1977. The enrolled bill would also permit Indian Health Service (IHS) facilities to receive Medicare and Medicaid funds for services provided to eligible persons under those programs. Each IHS facility not presently meeting Medicare or Medicaid standards would be required within six months of enactment of the enrolled bill to develop a plan to meet the requirements of those programs. The facility could then receive Medicare and Medicaid funds for one year without meeting the usual requirements of those programs, but after that only if those

requirements had been met. The Federal government would completely reimburse States for Medicaid funds paid to IHS facilities. S. 522 would in addition direct the Secretary to conduct a study concerning the need for and feasibility of an Indian school of medicine, to promulgate regulations under the enrolled bill within ten months of enactment, and to develop a plan of implementation within 240 days of enactment. Funds appropriated under S. 522 would remain available until expended.

We opposed this bill consistently during its consideration by the Congress because it would authorize a number of specific programs duplicating our present general authority in this area and because the additional appropriation authorizations implied a congressional desire to exceed our budget requests in the area of Indian health. At this stage, however, we feel that other considerations strongly suggest that the President sign S. 522.

The enrolled bill would for the first time permit Native Americans effectively to use Medicare and Medicaid benefits for which they are eligible; these benefits cannot under present law be used in Federal facilities (except in certain restricted situations). If Native Americans are to be fully integrated into the mainstream of the American health care system, and in particular in terms of a future national health insurance program, they must be given meaningful participation in, and develop familiarity with, the most extensive programs we have in this area to date.

The enrolled bill does not contain, as did earlier versions of the bill, any authorizations for fiscal year 1977. In any event, the bill's authorizations merely duplicate existing authority. The enrolled bill, moreover, is viewed by many Native Americans, Congressmen, and other persons concerned with the welfare of Native Americans as a statement of Federal commitment to advance the welfare of our Native Americans. During congressional consideration, our objections to provisions in the bill were part of a dialogue in developing the best possible approach in the area of Indian health. At this stage, however, the Administration can only approve

or disapprove the bill as a whole. The President's approval of this bill would reaffirm the Administration's real concern for and interest in Native Americans; disapproval would adversely affect the view Native Americans and others have as to the Administration's commitment to Native Americans.

The enrolled bill was passed by the Senate by a vote of 78 to 0, and in an earlier version by the House by a vote of 310 to 9.

We recommend that the President sign the enrolled bill.

Sincerely,

Marjorie Lynch

Under Secretary

United States Department of the Interior

OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20240

SEP 22 1976

Dear Mr. Lynn:

This responds to your request for the views of this Department on the enrolled bill S. 522, "To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes."

We recommend that the President approve the enrolled bill.

While the administration of the Indian health care program is not under the jurisdiction of the Bureau of Indian Affairs, we recognize the urgent need to upgrade the quantity and quality of health services sufficiently to insure adequate health care for Indians and Alaska Natives. The unmet health needs of the American Indian and Alaska Native people are severe and their health status and average life expectancy are far below that of the general population of the United States. In many cases, the poor health status of these people affects their ability to fully participate in and derive the economic, educational and social benefits that accrue to them from programs administered by the Federal Government. Because the low health status of the American Indian and Alaska Native people is one of the most critical problems they confront, efforts to ameliorate this condition are vitally necessary. Delivery of adequate health services is a major cornerstone upon which rests the success of all other Federal programs for the benefit of Indians.

The purpose of S. 522 is to insure a significant improvement in the health status of the American Indian and Alaska Native people. The enrolled bill would authorize the financial resources needed to overcome the inadequacies in the existing Indian health care program. Further, S. 522 would invite the greatest possible participation of Indians and Alaska Natives in the direction and management of that program. In view of the legislative authorities handed down in Public Law 93-638, the "Indian Self-Determination and Education Assistance Act", programs and authorities such as those contained in S. 522 could not be more timely. We see potential in Titles II and III of the enrolled bill whereby some of the health services and health facility improvements proposed might be performed under

grant or contract with tribal governments instead of directly by the Indian Health Service. The bill authorizes approximately $480 million in appropriations over a three-year period.

Sections 201(c)(4)(C) and 304 of the enrolled bill include provisio that involve the Bureau of Indian Affairs, and we look forward to working with the Indian Health Service towards implementing them.

The generally low health status of Indian people adversely impacts the social and cultural fiber of their communities, and contributes to the high attendant rates of mental illness, alcoholism, accident homicide and suicide. Because of this condition, which pervades many reservations, the attainment of true economic self-sufficienc is almost impossible.

Despite the fine accomplishments of the Indian Health Service, muc remains to be done, and can only be accomplished through a progra such as that in S. 522. This, in great part, is due to the outda and inadequate IHS health facilities, one half of which do not me the standards for national hospital accreditation. There is also an acute manpower shortage among physicians and related health personnel - there is approximately one IHS physician for every 9 Indians in Indian country, while the national ratio is about one doctor per 600 persons.

As the Department primarily charged with carrying out the Federal responsibility to Indians and promoting their general welfare, w believe it is essential that the President affirm the commitment improved Indian health as embodied in S. 522, and which has rece the overwhelming endorsement of the Indian people.

Sincerely yours,

Acting Secretary of the Inte

Honorable James T. Lynn
Director, Office of
Management and Budget
Washington, D.C. 20503